U.S. PUBLIC HEALTH SERVICE
FEDERAL OCCUPATIONAL HEALTH

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
Appendix C to Sec. 1910.134:

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Can you read? (select one): Yes ☐ No ☐

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print). Today's date _____

_____ Name

_____ Job Title

_____ Age

Male/ Female (circle one)

_____ Height (ft, in)

_____ Weight (lbs)

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):

_____

The best time to phone you at this number:

_____

Has your employer told you how to contact the health care professional who will review this questionnaire (select one): Yes ☐ No ☐

Check the type of respirator you will use (you can check more than one category):

a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b. _____ Other type

☐ powered-air purifying,

☐ half- face

☐ supplied-air,

☐ full-facepiece type,

☐ self-contained breathing apparatus.

Have you worn a respirator (select one): Yes ☐ No ☐

If ``yes," what type(s):_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please select ``yes" or ``no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month Yes ☐ No ☐

2. Have you ever had any of the following conditions?

Seizures (fits)	Yes ☐ No ☐
Diabetes (sugar disease)	Yes ☐ No ☐
Allergic reactions that interfere with your breathing	Yes ☐ No ☐
Claustrophobia (fear of closed-in places)	Yes ☐ No ☐
Trouble smelling odors	Yes ☐ No ☐

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis	Yes ☐ No ☐
Asthma	Yes ☐ No ☐
Chronic bronchitis:	Yes ☐ No ☐
Emphysema:	Yes ☐ No ☐
Pneumonia	Yes ☐ No ☐
Tuberculosis	Yes ☐ No ☐
Silicosis	Yes ☐ No ☐
Pneumothorax (collapsed lung)	Yes ☐ No ☐
Lung cancer	Yes ☐ No ☐
Broken ribs:	Yes ☐ No ☐
Any chest injuries or surgeries:	Yes ☐ No ☐
Any other lung problem that you've been told about:	Yes ☐ No ☐

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath:	Yes ☐ No ☐
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Yes ☐ No ☐
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ☐ No ☐
Have to stop for breath when walking at your own pace on level ground:	Yes ☐ No ☐
Shortness of breath when washing or dressing yourself:	Yes ☐ No ☐
Shortness of breath that interferes with your job:	Yes ☐ No ☐
Coughing that produces phlegm (thick sputum):	Yes ☐ No ☐
Coughing that wakes you early in the morning:	Yes ☐ No ☐
Coughing that occurs mostly when you are lying down:	Yes ☐ No ☐
Coughing up blood in the last month:	Yes ☐ No ☐
Wheezing:	Yes ☐ No ☐
Wheezing that interferes with your job:	Yes ☐ No ☐
Chest pain when you breathe deeply:	Yes ☐ No ☐
Any other symptoms that you think may be related to lung	Yes ☐ No ☐

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	Yes ☐ No ☐
Stroke:	Yes ☐ No ☐
Angina:	Yes ☐ No ☐
Heart failure:	Yes ☐ No ☐
Swelling in your legs or feet (not caused by walking):	Yes ☐ No ☐
Heart arrhythmia (heart beating irregularly):	Yes ☐ No ☐
High blood pressure:	Yes ☐ No ☐
Any other heart problem that you've been told about:	Yes ☐ No ☐

6. Have you ever head any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest	Yes ☐ No ☐
Pain or tightness in your chest during physical activity	Yes ☐ No ☐
Pain or tightness in your chest that interferes with your job	Yes ☐ No ☐
In the past two years, have you noticed your heart skipping or missing a beat :	Yes ☐ No ☐
Heartburn or symptoms that is not related to eating	Yes ☐ No ☐
Any other symptoms that you think may be related to heart or circulation problems:	Yes ☐ No ☐

7. Do you currently take medication for any of the following problems?

Breathing or lung problems:	Yes ☐ No ☐
Heart trouble:	Yes ☐ No ☐
Blood pressure:	Yes ☐ No ☐
Seizures (fits):	Yes ☐ No ☐

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9) Yes ☐ No ☐

Eye irritation:	Yes ☐ No ☐
Skin allergies or rashes:	Yes ☐ No ☐
Anxiety:	Yes ☐ No ☐
General weakness or fatigue:	Yes ☐ No ☐
Any other problem that interferes with your use of a respirator:	Yes ☐ No ☐

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes ☐ No ☐

Questions 10-15 below must be answered by every employee who has been selected to use either a ***full-facepiece*** respirator or a ***self-contained breathing apparatus (SCBA)***. For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently): Yes ☐ No ☐

11. Do you currently have any of the following vision problems?

Wear contact lenses:	Yes ☐ No ☐
Wear glasses:	Yes ☐ No ☐
Color blind:	Yes ☐ No ☐
Any other eye or vision problem:	Yes ☐ No ☐

12. Have you ever had an injury to your ears, including a broken ear drum: Yes ☐ No ☐

13. Do you currently have any of the following hearing problems?

Difficulty hearing:	Yes ☐ No ☐
Wear a hearing aid:	Yes ☐ No ☐
Any other hearing or ear problem:	Yes ☐ No ☐

14. Have you ever had a back injury: Yes ☐ No ☐

15. Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet:	Yes ☐ No ☐
Back pain:	Yes ☐ No ☐
Difficulty fully moving your arms and legs:	Yes ☐ No ☐
Pain or stiffness when you lean forward or backward at the waist:	Yes ☐ No ☐
Difficulty fully moving your head up or down:	Yes ☐ No ☐
Difficulty fully moving your head side to side:	Yes ☐ No ☐
Difficulty bending at your knees:	Yes ☐ No ☐
Difficulty squatting to the ground:	Yes ☐ No ☐
Climbing a flight of stairs or a ladder carrying more than 25 lbs:	Yes ☐ No ☐
Any other muscle or skeletal problem that interferes with using a respirator:	Yes ☐ No ☐

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. **In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen:** Yes ☐ No ☐

If ``yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes ☐ No ☐

2. **At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals**: Yes ☐ No ☐

If ``yes," name the chemicals if you know them: _____

_____

Have you ever worked with any of the materials, or under any of the conditions, listed below:

Substance/Conditions			**Description of exposure (only if answer is yes)**
Asbestos	Yes ☐	No ☐	
Silica (e.g., in sandblasting)	Yes ☐	No ☐	
Tungsten/cobalt (e.g., grinding or welding this material)	Yes ☐	No ☐	
Beryllium:	Yes ☐	No ☐	
Aluminum	Yes ☐	No ☐	
Coal (for example, mining)	Yes ☐	No ☐	
Iron:	Yes ☐	No ☐	
Tin:	Yes ☐	No ☐	
Dusty environments:	Yes ☐	No ☐	
Any other hazardous exposures:	Yes ☐	No ☐	

4. **List any second jobs or side businesses you have**: _____

_____

5. **List your previous occupations**: _____

_____

6. **List your current and previous hobbies:** _____

_____

7. **Have you been in the military services?** Yes ☐ No ☐

If ``yes," were you exposed to biological or chemical agents (either in training or combat): Yes ☐ No ☐

8. **Have you ever worked on a HAZMAT team?** Yes ☐ No ☐

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes ☐ No ☐

If ``yes,'' name the medications if you know them: _____

10. Will you be using any of the following items with your respirator(s)?

HEPA Filters: Yes ☐ No ☐
b. Canisters (for example, gas masks): Yes ☐ No ☐
c. Cartridges: Yes ☐ No ☐

11. How often are you expected to use the respirator(s) (select ``yes'' or ``no'' for all answers that apply to you)?:

a. Escape only (no rescue): Yes ☐ No ☐
b. Emergency rescue only: Yes ☐ No ☐
c. Less than 5 hours per week: Yes ☐ No ☐
d. Less than 2 hours per day: Yes ☐ No ☐
e. 2 to 4 hours per day: Yes ☐ No ☐
f. Over 4 hours per day: Yes ☐ No ☐

12. During the period you are using the respirator(s), is your work effort:

Light (less than 200 kcal per hour): Yes ☐ No ☐	If ``yes,'' how long does this period last during the average shift:_____ hrs. _____ mins.
Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines	
Moderate (200 to 350 kcal per hour): Yes ☐ No ☐	If ``yes,'' how long does this period last during the average shift:_____ hrs. _____ mins.
Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.	
Heavy (above 350 kcal per hour): Yes ☐ No ☐	If ``yes,'' how long does this period last during the average shift:_____ hrs. _____ mins.
Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).	

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes ☐ No ☐

If ``yes,'' describe this protective clothing and/or equipment: _____

_____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes ☐ No ☐

15. Will you be working under humid conditions: Yes ☐ No ☐

16. Describe the work you'll be doing while you're using your respirator(s): _____

_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

_____

_____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of Toxic Substance	Estimated maximum Exposure level per shift	Duration of exposure per shift

The name of any other toxic substances that you'll be exposed to while using your respirator:

_____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

_____

_____

_____

To the best of my knowledge, the information I have provided is true and accurate.

_____ _____

Employee Name Date

_____

Employee Signature

Employee name:_____ Age____ Sex____ Date of birth:_____

Agency:_____ Work location:_____ Job title:_____

Supervisor's name:_____ Supervisor's phone: _____ fax:_____

Type of respirator use requested: __disposable, __ negative pressure (cartridge), __PAPR, __airline, __SCBA

I. Basis for recommendations on respirator clearance:

Recommendations below on medical clearance for respirator use are based on a review of **(check all that apply)*:***

__ Mandatory OSHA Respirator Medical Evaluation Questionnaire

__ Records of a medical examination, including physical exam, done on:_____

__ Additional information supplied by employee's personal physician.

__ Other information (specify): _____

II. Recommendations on medical clearance for respirator use: *(Choose A, B or C below)*

☐ **A. The employee is given medical clearance to use the following respirator(s) under the conditions noted** *(choose all that apply)*

__ N, R or P disposable respirator (filter-mask, non-cartridge type only)	__ Supplied air (air line) respirator
__ Negative pressure air-purifying (cartridge) respirator -- either half- or full-face	__ Self-contained breathing apparatus (SCBA)
__ Powered air purifying respirator (PAPR) -- either half or full face	

When using respirators, the employee is approved to perform the following (choose one)

__ Mild exertion /low heat stress

__ Moderate exertion

__ Heavy exertion

__ Escape only

__ Normal job duties

__Other Activity _____

Mild exertion *(2-3 mets) e.g. lifting up to 10 lbs, extended walking on a flat surface, extended standing*
Moderate exertion *(4-5 mets) e,g, lifting 10 lbs, 5 lifts per min, fast walking (4 mph), gardening/digging, pushing, pulling*
Heavy exertion *(5-10 mets) e.g. jogging (10 min/mi), chopping wood, climbing hills, life-saving activities, fire fighting*

This respirator clearance expires (circle one) *1 2 3 4 5 years from the date below (*If not marked, clearance expires in 1 year*)*

☐ **B. The employee is not given medical clearance for respirator use because more information is needed** *(Specify what is needed to make a decision)*

☐ 1. A medical examination, including a physical exam*, is needed to make a decision*

*- *Please use the FOH Medical Surveillance Health History and Physical Evaluation forms for this*

☐ 2. The following additional information is needed for review (*specify what):*

_____

_____

☐ **C. The employee is not given medical clearance for respirator use because of the health problems as noted below** *(choose one below)*

☐ 1. A temporary health problem (which should be reevaluated in _____ months)

☐ 2. A health problem that appears permanent (routine re-evaluation is not needed)

_____ _____

Examiner / Reviewer Name (Print) Phone number for questions

_____ Date:_____

Examiner / Reviewer Signature Print Health Center Stamp above